Consent Form for Denied Prior Authorizations

Date: ___________________

Member Name: ____
(First, Last)

Member Date of Birth: _______________________________
(MM/ DD /YYYY)

Insurance Plan & Member ID Number : _________________________ / ______________________
(Insurance) (ID #)

I authorize ____ to appeal on my
(Provider Full Name/ Title)

behalf for the prior authorization denial of ____________________________________.
(Medication Name)

Parent/legal guardian printed name (if patient is under 18 years of age):

____

Parent/legal guardian Signature:

____

Member printed name (if patient is 18 years or older):

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Member Signature:

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